RETIRED MUNICIPALTEACHER ENROLLMENT (FORM-RMT)

Health and Basic Life Insurance

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐M ☐F	Date of Birth / /	Agency/Division # (GIC use only) /
	Name – Last	First		MI
Address	Street	City	State	Zip
Contact Information	Preferred Phone ( )	Preferred Email	Country *(if not USA)*	
Claim Number	Insured's Medicare Claim #	Spouse's Medicare Claim #		
Retirement Information	Name of Municipality or school district retired from	Will you receive a monthly pension from a public retirement system? ☐Yes ☐No	Date of Retirement / /	

HEALTH AND BASIC LIFE

☐ **Basic Life Only** ☐ **Basic Life and Health**

MEDICARE PLAN

Select ONLY **ONE** if you and/or your spouse/covered dependents are enrolled in Medicare

Massachusetts, New England & Nationwide Residents:
- ☐ Harvard Pilgrim **Medicare Enhance (Supplement)**
- ☐ Health New England **Medicare (Supplement)**
- ☐ UniCare **Medicare Extension (Supplement)**

Massachusetts Residents (limited service area):
- ☐ Tufts **Medicare Preferred (Advantage)***

* Contact plan for Massachusetts service area and provider network information.

Medicare Coverage Election
- ☐ Individual
- ☐ Individual and spouse
- ☐ Family

Check all that apply:
- ☐ Individual on Medicare
- ☐ Spouse on Medicare
- ☐ Dependent(s) on Medicare

NON-MEDICARE PLAN

Select ONLY **ONE** if you and/or your spouse/covered dependents are not enrolled in Medicare

Massachusetts Residents
- ☐ Harvard Pilgrim **Quality (HMO)**
- ☐ Health New England **(HMO)**
- ☐ Mass General Brigham Health Plan **Complete (HMO)**
- ☐ UniCare **Community Choice (PPO-TYPE)**

Massachusetts & New England Residents:
- ☐ Harvard Pilgrim **Explorer (POS)**
- ☐ UniCare **Total Choice (Indemnity)**
- ☐ UniCare **Plus (PPO-TYPE)**

Nationwide excluding New England Residents:
- ☐ Harvard Pilgrim **Access America (PPO)**

Non-Medicare Coverage Election:
- ☐ Individual
- ☐ Family

SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐ Add ☐ Drop					/ /	☐M ☐F	
☐ Add ☐ Drop					/ /	☐M ☐F	
☐ Add ☐ Drop					/ /	☐M ☐F	
☐ Add ☐ Drop					/ /	☐M ☐F	

FORMER SPOUSE INFORMATION If Listed Above

Are you remarried? ☐Yes ☐No	Date of your remarriage: / /	Has your former spouse remarried? ☐Yes ☐No	Date of Divorce: / /
			Date of former spouse's remarriage: / /
Address: Street		City	State / Zip

SIGNATURE REQUIRED

AUTHORIZATION – I have read the instructions on the reverse side of this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. If premiums are not deducted enrolled members will receive a monthly bill for premiums due. I understand that my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. **You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you.**

Signature of Applicant: _____ Date: _____

CERTIFICATION OF RETIRING TEACHER'S INSURANCE COVERAGE (REQUIRED)

To be completed by Payroll/Insurance Coordinator at your Municipality/school district.

I certify that the above applicant is currently covered under our local life and/or health insurance program and will be covered until his/her retirement coverage begins the first day of the third month after the date of retirement. I will notify the Group Insurance Commission if coverage is interrupted before the retirement coverage begins, or if the date of retirement changes.

Signature: _____ Date: _____

Please Print Name and Title: _____

(See over for instructions)

GIC RMT ENROLLMENT FORM (FORM-RMT) INSTRUCTIONS

Eligibility for benefits through the Group Insurance Commission

If you are a retiring teacher from a city, town or school district whose municipality has elected to participate in the GIC's RMT program and will be receiving a pension from the Massachusetts Teachers Retirement System (MTRS), you are eligible to apply for GIC benefits. If you do not elect benefits at retirement, you may apply for GIC benefits during the GIC's annual enrollment, or within 60 days of a qualifying event (examples include marriage, divorce, or involuntary loss of other coverage).

IMPORTANT: To apply, you must have at least basic life insurance and/or health insurance through the GIC participating city/town/school district on the date of your retirement. If you do not have these benefits on the day you retire, you are not eligible to enroll in GIC benefits. If there is a change to your date of retirement, this may affect your eligibility for GIC benefits.

Use this form for enrolling in GIC benefits for the first time at retirement.

For an overview of your GIC benefit options, see your GIC Benefit Guide at mass.gov/GIC

Deadlines and Required Documentation

- **Required documentation:** To add a spouse or dependent to coverage, documentation is required. Do not send original documents because they will not be returned. Visit our website for the Required Documentation list: mass.gov/info-details/gic-forms.
- If you and/or your spouse is **Medicare eligible**, the following is needed:
  - Indicate your and/or your spouse's Medicare Claim number on the front of this form.
  - If you and/or your spouse are over age 65 and ***not eligible for Medicare***, the following document must accompany this form:
    - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.

Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare. When selecting your plan, be sure to choose "individual" Non-Medicare coverage if only covering one Non-Medicare family member; select "family" Non-Medicare coverage if covering two or more Non-Medicare family members.

If enrolling in one of GIC's Medicare Plans, you will be automatically enrolled in the GIC's SilverScript Medicare Part D prescription drug plan. After your enrollment is processed by the GIC, you will receive a mailing from SilverScript with information about the plan and advising you that you have the choice to opt out of the prescription drug plan. The opt-out letter is required by Medicare, but we do not recommend that you do so because **if you opt out of SilverScript, you will lose your GIC medical, prescription drug and behavioral health coverage**.

Your health insurance election includes basic life insurance (this amount is determined by your city/town/school district). Please be sure to complete and include GIC Beneficiary Form - Form 319 *(one to three beneficiaries)* or G-500 *(four or more beneficiaries or special designations, such as estate or trust)* with your enrollment form.

If electing GIC Retiree Dental, the Retiree Dental Enrollment/Change Form (Form-RD) must also be completed.

Coverage Effective Date

You should apply for coverage two months before your retirement date. Coverage begins on the first day of the third month following your retirement date. For example, if you retire on any day in June, your coverage begins on September 1st. If you have questions about your coverage after your retirement and before your effective date with the GIC, contact your city/town/school district.

Note: The GIC will validate with the Teachers' Retirement Board that you are receiving a monthly pension to determine continued eligibility for GIC benefits.

Form and Document Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

MAIL: Return completed form and documentation to:

Group Insurance Commission
PO Box 556, Randolph, MA 02368